Report to the Legislature

FY01-03 Utilization and Cost Containment Initiative

Chapter 7, Laws of 2001, E2, Section 209(1)

September 1, 2002

Department of Social & Health Services
Medical Assistance Administration
Division of Business & Finance
PO Box 45500
Olympia, WA 98504-5500
(360) 725-1870
Fax: (360) 586-7498

FY01-03 Utilization and Cost Containment Initiative
Report to the Legislature – September 1, 2002

TABLE OF CONTENTS

FY01-03 Utilization and Cost Containment Initiative
Report to the Legislature – September 1, 2002

Executive Summary

Legislative Mandate - Chapter 7, Laws of 2001, E2, Section 209(1), the Operating Budget, provides that "The department (of Social & Health Services) shall increase its efforts to restrain the growth of health care costs." The chapter law adds, "The appropriations in this section anticipate that the department implements a combination of cost containment and utilization strategies sufficient to reduce general fund--state costs by approximately 3 percent below the level projected for the 2001-03 biennium in the March 2001 forecast." This established a target of $50 million in State savings for the 2001-03 biennium.

Accomplishments in Utilization and Cost Containment Initiative (UCCI) - Excluding the Family Planning Waiver and Therapeutic Consultation Service (TCS), cumulative savings through June 02 are:

July 2001 Through June 2002	**Total** (millions)	**State** (millions)
The FY02 net savings goal: (After expenses and excluding F.P. Waiver and TCS)	$ 27.60	$ 13.74
Gross Savings Increase from UCCI:	$ 45.57	$ 22.58
UCCI Expenses:	$ (1.87)	$ (0.85)
Net UCCI Savings:	$ 43.70	$ 21.73

The Medical Assistance Administration (MAA) is ahead of it's savings goal by $8.0 million (State). These savings result from directly countable activities. Comparison of savings with the March 2001 forecast is a complex task. The Senate and the Office of Financial Management have hired a consultant, The Lewin Group, to assist.

Utilization and Cost Containment Initiative in 2003 – MAA will continue, and to a degree, will grow the current savings components. There will also be new components considered, for example:

- MAA has found that the time it takes for certain Medicaid clients to become Medicare eligible can be reduced. Once Medicare is approved, coverage is retroactive to the date of the client's application. Expedited Medicare application and eligibility is being developed by MAA on a pilot basis.

- In May, 2002, MAA stopped paying for drugs for Washington's Medicaid-eligible veterans in VA nursing homes, and is now exploring the means to also hold VA (the federal agency) accountable for the cost of drugs for Medicaid-eligible veterans residing in any nursing home in Washington.

- In September 2002, the MAA will begin paying significantly lower rates for dialysis than in past years. In addition, Medicare eligibility will be expedited for many dialysis patients formerly covered only by Medicaid.

- Mail order pharmacy services. (See "FY02 Supplemental Budget - Expanding the Mandate", pages 1 and 2.)

- Explore potential savings from increased use of generics and fewer calls for authorization of non-preferred drugs, due to prescribers having access to MAA's Preferred Drug List, via their hand-held electronic device (palm pilot).

FY01-03 Utilization and Cost Containment Initiative
Report to the Legislature – September 1, 2002

I. Introduction

A. FY01-03 Legislative Proviso

Chapter 7, Laws of 2001 E2, Section 209(1), the Operating Budget, provides that "The department (of Social & Health Services) shall increase its efforts to restrain the growth of health care costs." Based on budget steps, legislative notes and follow-up discussions, overall 2001-03 savings requirements are a net 50 million general fund-state (GF-S) dollars plus a net 32 million general fund-federal (GF-F) dollars. "Net savings" are total savings minus the cost of additional UCCI staff, and other administrative costs directly tied to the initiative.

Chapter 7, Section 209(1) adds that, "If satisfactory progress is not being made to achieve the targeted savings, the reports shall include recommendations for additional or alternative measures to control costs."

UCCI goals were set slightly above the net $82 million requirement. The higher goal provides a margin of safety in achieving the full $82 million in savings over the biennium.

B. Savings Components, Baseline Savings, and Goals

Four utilization and cost containment components were traditional activities which were strengthened in FY02. Thus, they have both a baseline level of savings plus a UCCI savings goal. These are 1) hospital audits, 2) medical/dental audits, 3) medical care quality review, and 4) coordination of benefits.

The other UCCI components were new in FY02 or had not had significant savings activity in prior years. The FY02 and 03 annual savings baselines, and the semi-annual and full-year UCCI savings goals are shown in Exhibits A and B. All UCCI components are briefly described in Exhibits C and D.

C. FY02 Supplemental Budget – Expanding the Mandate

2002 Legislative decisions requiring new savings will directly impact the Utilization and Cost Containment Initiative in FY03. To assure that savings are not double counted by the separate initiatives, coordination of reporting/evaluation will be enhanced. The following paragraphs briefly describe the new activities.

1. Increase the Discount on Brand Name and Multi-source Drugs and Initiate Mail Order Purchasing

The 2002 legislature reduced the FY2003 drug program budget by $24.4 million ($12.4 State). Legislative budget notes state:

"The 'AWP', or 'average wholesale price', is the list price assigned to a drug by its manufacturer. However, manufacturers typically sell the drug to wholesalers and retailers for substantially less than this list price, and most third-party payers in turn pay

participating pharmacies for drug costs at a discounted percentage of the AWP. Washington's Medical Assistance program has for a number of years paid 89% of the AWP for single-source drugs, and 89% of the AWP of the third-lowest priced generally available label for generics." *(Budgeted savings of $21.7 million.)*

"As an alternative, the legislative budget anticipates that the Medical Assistance program will pay 86% of the AWP for single-source drugs, and 50% of AWP for drugs for which there are multiple *(five or more)* generic versions."

"The department may pay higher rates for drug ingredients than identified here, to the extent that the cost of the higher payment rates is offset by alternative cost-control mechanisms in the pharmacy program. Such alternative mechanisms must be (1) developed in consultation with the state pharmacy association; (2) likely to prove effective, based upon the documented experience of other similar programs; and (3) not necessary to achieve the utilization and cost-control initiative savings targets already established for the pharmacy program."

After some four months of meetings with a coalition of pharmacy and retail association representatives, the Medical Assistance Administration concluded that alternative savings strategies proposed by the coalition would not result in the needed savings by June 30, 2003. Given this analysis and the still uncertain savings impact of Therapeutic Consultation Service (see below), MAA implemented the legislatively set discount increases on August 1, 2002.

2. Mail Order Drugs

Legislative budget notes state, "The Budget further anticipates that the Medical Assistance program will begin providing a mail-order pharmacy option for its clients no later than January 2003." *(Budgeted savings of $2.7 million.)*.

With the August 1 implementation of increased AWP discounts, a number of pharmacies in low population areas of the state decided not to serve Medicaid clients. For that reason, MAA immediately began negotiations with private mail order companies to provide service as soon as possible.

3. Brokered Interpreter Services

Finally budget notes state, "the budget anticipates that the current method of purchasing interpreter services is replaced with a new "brokerage" model by January 2003, for all DSHS programs. Under the brokerage model, DSHS will contract at a specified rate with any qualified individual or agency, and will also contract with intermediaries who will schedule and link interpreters with clients and service providers."

Note: For more information about UCCI, call MAA at (360) 725-1870 or contact ***hancodj@dshs.wa.gov***.

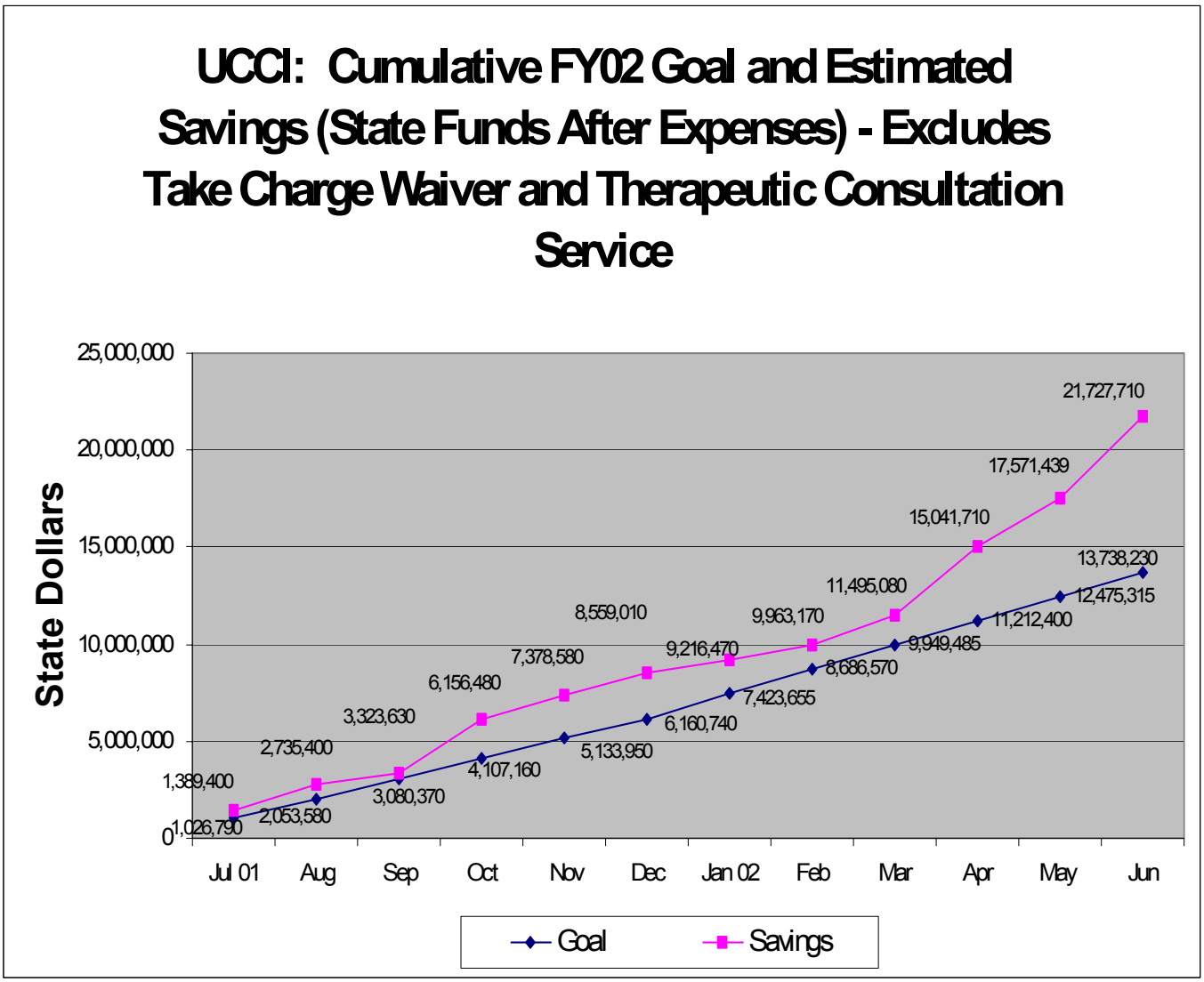
II. Progress Report

A. First Year (FY02) Preliminary Results

With the adoption of savings goals, the addition of new UCCI staff, and with monthly tracking of progress toward goals, the MAA staff have moved strongly into systematic and thorough review of Medicaid expenditures with an eye on cost containment goals.

The overall FY2002 UCCI savings goal (the amount above the baseline savings requirement and after expenses), was $ 27.6 million ($13.74 million State). This goal excludes the Family Planning (Take Charge) Waiver and Therapeutic Consultation Service components.

Savings are measured by two independent methods, namely, by comparison with the March 2001 forecast and secondly, by tracking savings from individual transactions and activities. This report provides the latter measurement (with the exclusions noted above). The cumulative monthly goal and the estimated FY02 savings in State funds, are as follows:



In FY02, all UCCI program managers met their savings goals (baseline plus UCCI increase), except that results are not yet in for Take Charge (Family Planning), and for Therapeutic Consultation Service. (See Exhibit E for details.) The most successful components were:

- Audits (hospitals and medical/dental providers) - As shown in Exhibit A, the FY02 baseline savings plus UCCI goal totaled $9.1 million ($4.5 million State). FY02 final audits resulted in $11.76 million ($5.8 m State) in recovered, or documented but not yet recovered, overpayments.

- The Coordination of Benefits - The FY02 baseline savings requirement was $87.9 million ($43.5 State) and the UCCI savings goal was $18.1 million ($9.0 m State). The unit realized $115.5 million ($57.2 m State) in recoveries and cost avoidance. Thus, the UCCI savings was $9.5 million ($4.7 State) above the FY02 goal.

B. The Take Charge (Family Planning) waiver program was implemented in July 2001 to provide education and prevention of unintended pregnancies. Savings will result from fewer deliveries and pre- and post-natal medical care. The earliest measurement period would begin nine months after program startup, or April 2002. A savings forecast is being developed by DSHS (MAA, Research and Data Analysis, Forecasting), and the Caseload Forecast Council. Preliminary results are expected by the end of 2002. See Exhibit D.

C. Getting Started with Therapeutic Consultation Service (TCS) - The Medical Assistance Administration's advisory board, the Drug Utilization and Education Council (DUEC), completed a legislative report in December 2000 that summarized the findings of a study of the feasibility of implementing a therapeutic interchange program for Medicaid's Fee-For-Service population. Four drug classes were recommended for a Preferred Drug List (PDL):

- Proton Pump Inhibitors (PPIs)
- Histamine H2 Receptor Antagonists (H2RAs)
- Non-sedating Antihistamines
- Statin-type cholesterol lowering agents

The first two drug classes were incorporated into the *Therapeutic Consultation Service* on February 1, 2002. Prescriber education began in June 2001 with MAA's presentation of the program to representatives of the Washington State Medical Association, the Washington State Pharmacists Association, and the National Association of Chain Drug Stores.

In December 2001, computer alerts to the pharmacists were initiated each time a non-preferred drug was processed for payment. Data were collected and analyzed to determine the impact of the early provider education on conversion rates of the PPIs and the H2RAs. Washington's medical providers immediately started writing prescriptions for the preferred drug in the two established drug classes. MAA estimates savings of about $120,000 per month (State) in the first seven months of fiscal year 2002.

In February 2002, the computer alerts were replaced by computer stops on claims for non-preferred drugs and for any Medicaid client's fifth prescription within 30 days. These triggers necessitated a phone call by the prescriber to the call center set up by MAA's contractor, Affiliated Computer Services. In July 2002, MAA added Voluntary Preferred Drugs to the PDL. These drugs are suggested to prescribers during TCS reviews. They include statin-

type cholesterol-lowering drugs, the non-sedating antihistamines, and the ACE-inhibitors (blood pressure lowering drugs). See Exhibit C for a description of TCS.

Measurement of TCS savings – Estimating the savings derived from TCS will be a challenging task. Direct savings through changes resulting from specific consultations can be measured. However, measuring the indirect effect on overall prescribing patterns is more difficult.

MAA began TCS services in February 2002. At least 5-7 months of expenditures are needed for statistical validity in estimating savings, and the department's Forecast office uses a standard 4- to 5-month lag to finalize expenditures. (Expenditures are "final" when 98 percent of bills are in and have been reconciled.) So in January 2003, we will have enough data that, with the aid of The Lewin Group, we can estimate TCS savings.

D. Internal Evaluation of UCCI

The same issues that arise when trying to estimate savings from TCS are also present when trying to estimate overall savings from the UCCI. Direct savings can be readily measured, and are provided in this report. Indirect savings resulting from changes in practice patterns which are induced by the UCCI activities are more difficult to assess. The Lewin Group will also be analyzing this area and recommending a methodology for estimating overall savings.

III. UCCI in FY2003

A. Potential New Components/Activities

1. Expedited Medicare Eligibility

MAA has found that Medicare eligibility is time-consuming to establish, but once approved, is generally retroactive to the date of the client's application. In cases where the client may be eligible for Medicare, the MAA must work with both the department's Economic Services Administration and with the Social Security Administration. In order to determine the best approach, expedited Medicare application and eligibility is being pursued by MAA on a pilot basis.

2. **Alternative Payers** – In May 2002, MAA started holding VA accountable for drugs for Washington's Medicaid-eligible veterans in VA nursing homes. The next step is to hold VA accountable the cost of drugs for Medicaid-eligible veterans residing in any nursing home.

3. **Kidney Dialysis Rates** – In FY03, MAA will begin paying significantly lower rates for dialysis than in past years. In addition, Medicare eligibility will be facilitated for many dialysis patients formerly covered by Medicaid.

4. **Mail Order Drugs** – As noted earlier in the report, MAA is working quickly to implement Mail Order service. There will be two phases, namely, fast start efforts recognizing providers who already provide mail order services in their geographic area, and adding one or more new providers to serve state wide, with emphasis in rural areas where access is most difficult. Phase two will be set up on a competitive bid basis with a goal of meeting the legislatively mandated savings target of $2.7 million in FY03.

5. **Palm Pilot availability of the Preferred Drug List (PDL) –** The return on investment (savings potential) is being assessed, of posting MAA's PDL in an electronic environment via EPOCRATES™ so that prescribers would have immediate access to the information. Savings would result from more frequent prescribing of generics and a reduced number of calls for authorization of non-preferred drugs. (This idea came from a community pharmacist in response to a letter from MAA to all pharmacists requesting ideas for saving money in the Medicaid program.)

B. Disease Management, Medicaid Waiver, and Payment Review Program

In FY02, MAA conducted community-based discussions of possible Medicaid program changes and cost control efforts. A federal waiver request was submitted to the Centers for Medicare and Medicaid (and later amended), that would allow certain changes such as co-payments on drugs for certain categories of eligible Medicaid clients. In addition, the MAA has implemented and will continue to develop the Disease Management approach to cost containment and quality improvement for clients who are high service users due to complex illnesses. These initiatives dovetail with UCCI in that they too have (or will have) specific savings goals.

As noted in the March 2002 report to the legislature, the **Payment Review Program** was started in CY2000. PRP has given DSHS increased ability to profile Medicaid clients' use of services and providers' claims for service reimbursement. This capability has aided UCCI Program Managers to target their cost containment efforts to providers and clients whose service use is above the norm for their Medicaid peers. The MAA will continue to expand its use of data and analysis for focusing on the areas where program and fiscal review are most needed. For more information on these efforts, contact the administration at the telephone and e-mail address at the end of Section I. of this report.

IV. Exhibits A through E follow.

Exhibit A

FY 2002 Baseline and Semi-Annual UCCI Savings Goals

30-Aug-02

	FY02 Savings Baseline	SEMI-ANNUAL UCCI SAVINGS INCREASE				FY2002 UCCI SAVINGS INCREASE		
		(July - December 01)		(January - June 02)		(July 01 - Jun 02)		
	(State + Federal)	State	Federal	State	Federal	State	Federal	Total
Audit Activity								
Hospital Audits	2,404,200	644,150	655,850	1,189,200	1,210,800	1,833,350	1,866,650	3,700,000
Medical Audits	300,000	672,640	684,860	672,640	684,860	1,345,280	1,369,720	2,715,000
Total Audit Activity	2,704,200	1,316,790	1,340,710	1,861,840	1,895,660	3,178,630	3,236,370	6,415,000
Quality Review and Prior Authorization Activitity								
Durable and Non Durable Medical	New	49,550	50,450	123,880	126,120	173,430	176,570	350,000
Pharmacy Program	2,466,100	179,250	195,750	537,750	587,250	717,000	783,000	1,500,000
Hospital DRGs	New	0	0	118,400	120,600	118,400	120,600	239,000
Medical and Dental Program	2,403,300	371,620	378,380	371,620	378,380	743,240	756,760	1,500,000
Total QRPAA	4,869,400	600,420	624,580	1,151,650	1,212,350	1,752,070	1,836,930	3,589,000
Increased Monitoring of Client Services								
Interpreter Services	New	24,780	25,220	49,550	50,450	74,330	75,670	150,000
Transportation Services	New	49,550	50,440	123,880	126,130	173,430	176,570	350,000
Total Monitor Activity		74,330	75,660	173,430	176,580	247,760	252,240	500,000
General Increase in Recoveries and Cost Avoidance								
Total COB & Tort Claims	87,866,400	4,492,599	4,574,201	4,492,599	4,574,201	8,985,199	9,148,401	18,133,600
Rates Development and Monitoring								
Additional Savings	New	0	0	396,400	403,600	396,400	403,600	800,000
Therapeutic Consultation Service								
4-Brand Rx Limit	New	0	0	4,966,600	5,033,400	4,966,600	5,033,400	10,000,000
Preferred Drug List	New	0	0	595,992	604,008	595,992	604,008	1,200,000
Family Planning Waiver								
Change in Pregnancy Rate	New	563,076	(3,299,671)	563,076	(3,299,671)	1,126,151	(6,599,341)	(5,473,190)
Total UCCI Savings Goals	95,440,000	7,047,215	3,315,480	14,201,587	10,600,128	21,248,802	13,915,608	35,164,400
FTEs & other Admin. Expense 1/		(863,800)	(979,226)	(1,011,416)	(1,427,263)	(1,875,216)	(2,406,489)	(4,281,705)
Net FY02 UCCI Savings Goals		6,183,400	2,336,300	13,190,200	9,172,900	19,373,600	11,509,100	30,882,700
1/ FY02 actual versus budgeted administrative expense.							(Totals rounded)	
File-H:/October 2002 Leg Rpt/Alloted Savings FY02 - Inflation in Base -Rev-A (8-30-02)								

Exhibit B

FY2003 Baseline and Semi-Annual UCCI Savings Goals

30-Aug-02		SEMI-ANNUAL UCCI SAVINGS INCREASES				FY2003 UCCI SAVINGS INCREASE		
	FY03 Savings	(July - December)		(January - June)		(July 02 - Jun 03)		
	Baseline	State	Federal	State	Federal	State	Federal	Total
Audit Activity	State + Fed. $							
Hospital Audits	2,440,700	1,164,420	1,185,580	1,164,420	1,185,580	2,328,840	2,371,160	4,700,000
Medical Audits	305,300	672,640	684,860	672,640	684,860	1,345,280	1,369,720	2,715,000
Total Audit Activity	2,746,000	1,837,060	1,870,440	1,837,060	1,870,440	3,674,120	3,740,880	7,415,000
Quality Review and Prior Authorization Activitity								
Durable and Non Durable Medical	New	148,650	151,350	173,425	176,575	322,075	327,925	650,000
Pharmacy Program	2,555,500	619,380	630,620	619,380	630,620	1,238,760	1,261,240	2,500,000
Hospital DRGs	New	123,880	126,120	123,880	126,120	247,760	252,240	500,000
Medical & Dental Program	2,438,900	495,500	504,500	495,500	504,500	991,000	1,009,000	2,000,000
Total QRPAA	4,994,400	1,387,410	1,412,590	1,412,185	1,437,815	2,799,595	2,850,405	5,650,000
Increased Monitoring of Client Services								
Interpreter Services	New	49,550	50,450	74,320	75,680	123,870	126,130	250,000
Transportation Services	New	148,650	151,350	148,650	151,350	297,300	302,700	600,000
Total Monitor Activity		198,200	201,800	222,970	227,030	421,170	428,830	850,000
General Increase in Recoveries and Cost Avoidance								
Coordination Of Benefits	89,819,800	4,999,640	5,090,460	4,999,640	5,090,460	9,999,280	10,180,920	20,180,200
Rates Development and Monitoring								
Additional Savings	New	957,859	972,141	957,859	972,141	1,915,718	1,944,282	3,860,000
Therapeutic Consultation Service								
ACS 4-Brand Rx Limit	New	4,966,600	5,033,400	4,966,600	5,033,400	9,933,200	10,066,800	20,000,000
Preferred Drug List	New	595,992	604,008	595,992	604,008	1,191,984	1,208,016	2,400,000
Family Planning Waiver								
Additional savings (Rev. 11-26-01)	New	3,595,720	(2,133,020)	3,595,720	(2,133,020)	7,191,440	(4,266,040)	2,925,400
Total UCCI Target	97,560,200	18,538,481	13,051,819	18,588,026	13,102,274	37,126,507	26,154,093	63,280,600
Administrative Expenses		(2,060,500)	(2,768,500)	(2,060,500)	(2,768,500)	(4,121,000)	(5,537,000)	(9,658,000)
Net FY03 UCCI Savings Goals		16,478,000	10,283,300	16,527,500	10,333,800	33,005,500	20,617,100	53,622,600
Net FY02 UCCI Savings Goals						19,373,600	11,509,100	30,882,700
Net FY02-03 UCCI Savings Goals						52,379,100	32,126,200	84,505,300
								Totals Rounded

Exhibit C. UCCI COMPONENTS – Brief Description

Hospital Audit

The audits address:

- Provider claims for services
- Third-party liability
- Spenddown amounts paid by the client to the provider, but not offset in the provider's Medicaid claim
- Hospital-based physician claims
- Ambulatory Surgery Center claims

Medical Provider Audit

The Medical Audit Unit is responsible for auditing many provider types including physicians, dentists, pharmacies, medical equipment providers, Federally Qualified Health Centers and numerous others.

Durable & Non-durable Medical Equipment – Quality Review

The Durable Medical Equipment (DME) unit of the Division of Medical Management (DMM), is the quality review program which has responsibility to prior approve, deny or request additional provider/client information for:

- Durable Medical Equipment
- Medical Supplies
- Orthotics and prosthetics
- Dental Services, and
- Orthodontic procedures and orthodontics for cleft palate and craniofacial anomaly treatments not provided by MAA-approved "specialty providers"

The unit provides cost avoidance through prior authorization, and post-payment review of claims for services and equipment. In addition, the unit develops and implements WAC and billing instructions to support service provision and cost control decisions, and coordinates testimony for fair hearings resulting from contested denials.

Pharmacy Program (Quality Review)

For purposes of Utilization and Cost Containment, the DMM pharmacy program unit provides prior authorization and post-payment review of claims for services. The unit also develops rules (WAC) and billing instructions to support prior authorization and cost control decisions. The program manager and toll-free line staff:

- Approve or deny requests for drugs that are on the prior authorization list
- Review the drug file and Expedited Prior Authorization (EPA) criteria for consistency

- Identify and follow up on inappropriate use of EPA numbers
- Resolve complex prescription related issues or refer for clinical review when necessary
- Identify prescribing/drug-use trends or patterns
- Resolve prescription drug program complaints
- Coordinate requests and compile and analyze prescriber, pharmacy and client utilization data
- Assure that MMIS/Point of Sale (POS) drug files are accurate and initiate corrections as necessary

Therapeutic Consultation Service - Four (4) - Brand Prescription Limit, and Preferred Drug List

Central to achieving the department goals for Therapeutic Consultation Service (TCS) is facilitating the involvement of the critical participants in the administration of drug therapy: the prescribing physician, the dispensing pharmacy, and the patient. Also crucial to ensuring program acceptance is making compliance with the program as convenient as possible.

As an initial step in smoothing program implementation, MAA's contractor, Affiliated Computer Services (ACS), provided Therapeutic Academic Service. Prior to startup (and ongoing thereafter) clinical pharmacists travel to physicians' offices and begin professional dialogue aimed at improving drug regimens and exploring clinically sound and cost-effective treatment options for Medicaid recipients. Therapeutic Academic Service consists of face-to-face detailing sessions with those physicians most impacted by the program.

Two pharmacists each visit 50 – 60 physicians per month. The pharmacists start with prescribers most impacted by the Therapeutic Consultation Service.

The Therapeutic Consultation Service process is initiated under two circumstances: when a claim for a non-preferred drug is submitted, or when a recipient exceeds the four brand prescriptions per month trigger. Regardless of which of the two circumstances initiate the process, the prescribing physician must call the TCS call center and enter into a therapeutic consultation with a clinical pharmacist.

When a pharmacy submits a claim for a non-preferred drug, the electronic claims processing system returns a reject message to the pharmacy notifying the provider that a non-preferred brand has been requested and therapeutic consultation is required. During those times when the physician cannot be contacted (after hours, holidays), the pharmacist has the option to issue an emergency supply.

If, during the drug regimen review, the TCS pharmacist determines that the patient's profile indicates the need for more intensive case management activity, the case can be referred to the Intensive Benefits Management program. This program focuses on the clinical evaluation of patients' treatment plans. While Therapeutic Consultation Services are primarily comprised of an intervention with a single physician, referral to the Intensive Benefits Management program provides for an in-depth review and subsequent coordination of care aimed at involving all providers rendering care to a given patient.

Intensive Benefits Management utilizes an integrated, drug-based case management model with specific goals to*:*

- Provide long-term case management of patients' prescription drug use
- Coordinate care among all of the patients' providers

- Support appropriate drug utilization and quality of care
- Promote cost-effective pharmaceutical care

Drugs in the following classes are not subject to the four brand prescription edit; they do not automatically trigger a review and do not count against a patient's four brands per month. These drug classes are:

- HIV medications
- Antidepressants
- Antipsychotics
- Immunosuppressants
- Hypoglycemia rescue agents
- Contraceptives
- Chemotherapy, and
- Generic Drugs

These are excluded because there is little or no opportunity for alternatives due to individual patient response to specific drugs in the class. However, they are not excluded from review for possible duplicate drug therapy or drug-drug interactions when another brand name is the trigger.

For now, nursing home clients are excluded from the 5th brand-name prescription trigger for Therapeutic Consultation Service. However, in the future, they may have the 5th brand prescription trigger included, if it appears that NH clients would benefit from Therapeutic Consultation Service.

Preferred Drug List - MAA chooses a drug or drugs from a selected therapeutic class for placement on the preferred list when the drugs in the class are essentially equal in terms of safety and efficacy.

MAA's current Preferred Drug List is as follows:

Therapeutic Class	Preferred Drug
Histamine H2 Receptor Antagonist	Ranitidine
Proton Pump Inhibitors	Protonix

Voluntary Preferred Drug List - The Drug Utilization and Education Council (DUEC) has continued to study additional drug classes to be considered for expansion of MAA's Prefered Drug List. Starting July 1, 2002 three additional drug classes were added to the list as Voluntary Preferred Drugs. Those three drug classes were the statin-type cholesterol-lowering drugs, the non-sedating antihistamines, and the ACE-inhibitors (blood pressure lowering drugs). The preferred drugs on the Voluntary Preferred Drug are suggested to prescribers during Therapeutic Consultation Service (TCS) reviews. The non-preferred drugs in these drug classes will not trigger a review unless they are the fifth request for a brand name drug in a calendar month. The DUEC will review the Calcium Channel Blockers and the Angiotensin II Receptor Blockers in October 2002.

Medical and Dental Provider Program (Quality Review)

The Division of Medical Management:

- Provides prior authorization of services
- Conducts pre- and/or post-payment review of provider billings
- Develops rules (WAC) and billing instructions to support prior authorization and cost control decisions
- Implements edits in the Medicaid Management Information System (MMIS), and
- Reviews provider data supporting billings/claims.

In addition, there is specific focus on:

- Diagnostic Related Group (DRG) reviews
- Necessity of and alternatives to certain hospital re-admissions

Interpreter Services Program

The department and its contracted medical providers are required under federal law to ensure equal access and effective communication for Limited English Proficient (LEP) clients, and deaf, deaf blind, and hard of hearing clients who access state-sponsored services.

MAA, in partnership with all of DSHS, increased recovery of overpayments by carrying out program reviews. Secondly, in cooperation with the Division of Medical Management, we initiated pre-payment claims review. This reduced payment and recovery of overpayments.

Non-Emergency Medical Transportation Program

The Medical Assistance Administration's Medical Transportation Program assures access to necessary non-emergency medical services for all eligible Department of Social and Health Services clients, most of whom are on Medicaid, that have no other means of transportation. MAA contracts with nine brokers who screen clients to ensure they are eligible prior to arranging the most appropriate, least costly method of transportation. Modes of transportation such as: public bus, gas vouchers, client and volunteer mileage reimbursement, nonprofit providers, taxi, cabulance, and commercial bus and air are utilized. Statewide, in FY 2001, the MAA transportation program provided approximately 2,030,000 trips (39,100 per week).

To improve control of utilization and cost, MAA has implemented the following:

- In Pierce County, we started new contracts for brokerage services in order to take advantage of local price and services competition.

- In King County where public transportation is generally available, we restructured screening and trip-distributing processes to ensure clients are only being assigned to lowest cost, appropriate, transportation providers.

- We initiated pre-payment review of claims from all broker agencies.

Coordination of Benefits (COB)

Coordination of Benefits staff have the primary responsibility to:

- Identify third-party commercial insurance resources
- Recover Medicaid payments made to clients who have third-party commercial insurance
- Resolve suspended claims that have third-party insurance resources.

Once a potential COB source has been verified, it is added to the MMIS, and all claims that MAA has paid during the coverage period are automatically identified and added to the billing file. COB staff edit and work the billing file so that appropriate invoices (within timely filing limits) can be generated and mailed to carriers, providers, etc., to recover funds. These efforts will be expanded in FY02-03 to meet the UCCI goals.

Rates Development and Monitoring

A. Adjust the Maximum Allowable Cost (MAC) Amount

Currently in the Fee Schedule there are many services and supplies for which the provider can be reimbursed at acquisition cost. Although MMIS currently checks the claim against a maximum allowable cost limit, these MACs need to be adjusted to more accurately reflect current acquisition cost. The result will be that the Medicaid Management Information System will flag incorrect billings, thereby avoiding over-payments, which would otherwise be identified only through an audit or quality review.

Determination of market acquisition cost is a very labor intensive effort because it requires on-going market research to document and then maintain the schedule of prices. This activity has begun and new prices will be immediately implemented in the system as the research is completed. In that way, savings will begin immediately.

B. Reimbursement for Kidney Centers

Up to September 2002, MAA reimburses Kidney Centers at the amount they bill. Effective in September, we begin paying free standing centers an amount based on their cost reports. Savings of about $3 million is anticipated in FY03.

IV. Exhibit D

Medical Assistance Administration
Take Charge Family Planning Waiver Update
August 2002

- The waiver creates a new 5-year demonstration and research program called TAKE CHARGE
- The research component includes 5 intervention and 5 control sites.
- Expands eligibility for Medicaid pre-pregnancy family planning services for women and men with family incomes at or below 200% Federal Poverty Level (FPL).
- The waiver was approved by CMS in March 2001. TAKE CHARGE was implemented July 1, 2001.

What are the most recent numbers of clients participating in TAKE CHARGE?

Month	Men	Women	Total
June, 2002	3,902	58,491	62,393

What are the most recent numbers of agencies and clinics participating in TAKE CHARGE?

Month	Agencies	Clinic Sites
July, 2002	66	169

What is the latest news on the 10 research sites?

- Analysis of 615 client surveys completed by TAKE CHARGE clients during their first TAKE CHARGE visit indicate that in the 2 months prior to their initial clinic visit 52% used a more effective birth control method (e.g., birth control pills, IUD), 32% used a less effective birth control method (e.g., condoms, natural family planning), 10% were abstinent and 6% used no birth control method.

- Collection of client surveys at the research sites is completed for Year One. Follow-up client surveys for Year One will begin to be mailed to clients starting in November 2002. The research sites began recruiting their new TAKE CHARGE enrollees for Year Two surveys in July.

Why is the TAKE CHARGE program so important?

- A goal of the TAKE CHARGE program is to decrease the number of unintended pregnancies and reduce the costs associated with state paid maternity care.

- *The preliminary evaluation for unintended pregnancy reduction is anticipated later this year.*

- *The hypothesis is that client-centered interventions will increase a client's successful use of her chosen birth control method.*

Exhibit E

Utilization and Cost Containment - FY2002 Goals and Estimated Savings By Component (State Funds)

(Excluding Family Planning Waiver & Therapeutic Consultation Service Programs)

File: All MAA - Revised 7-17-02	Baseline Savings Requirement	UCCI GOAL (Amount above Baseline)	UCCI Savings	Difference
	STATE $	STATE $	STATE $	STATE $
Field Audits				
Hospital	1,191,280	1,833,350	1,987,110	153,760
Medical/Dental	148,650	1,345,280	2,503,390	1,158,110
Quality Review and Prior Authorization				
Durable and Non-Durable Medical		173,420	446,620	273,200
Medical & Dental Program	1,190,840	743,250	1,114,870	371,620
Pharmacy Program	1,221,950	743,250	1,522,330	779,080
Hospital DRGs-Upcoding		118,420	0	(118,420)
Monitoring of Client Services Contracts				
Interpreter Services		74,330	186,070	111,740
Transportation Services		173,430	647,130	473,700
Coordination of Benefits	43,537,800	8,985,200	13,713,310	4,728,110
Alternate Payors				
VA Nursing Home - Drugs			57,780	57,780
Rates Development and Monitoring:				
Out-of-State Rates			24,830	24,830
C2 drugs (Narcotics)		396,400	372,370	(24,030)
Therapeutic Consultation Service **		Not Applicable		
Family Planning **		Not Applicable		
Totals (Before Administrative Expense)	47,290,520	14,586,330	22,575,810	7,989,480
Administrative Expenses:				
UCCI FTEs		(828,100)	(828,100)	
Consultants		(20,000)	(20,000)	
FY02 Estimated State $ Savings (without FP and TCS programs):		$ 13,738,230	$ 21,727,710	$ 7,989,480

** Additional months of service are needed before savings from Family Planning and TCS can be measured.